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To: ALL INTERESTED PARTIES

From: Department of Managed Health Care

The following is a brief summary of the comments and events that occurred during the Financial Solvency Standards Board (FSSB) meeting held on August 9, 2006.

I. Opening Remarks and Adoption of Meeting Minutes

Committee Chairperson Scott Syphax called the August 9th meeting of the Financial Solvency Standards Board of California to order at 10:00 a.m. All the members, for the record, are in attendance except for board member Andrew Myers. The minutes from the January 31, 2006 meeting were adopted.

II. Swipe/Smart Card Technology

Presentations were given regarding swipe/smart card technology. Copies of the power points presented are posted on the Department's website.

A swipe/smart card is typically a credit card sized badge/card incorporating a magnetic strip, an RFID tag, a transponder device, and/or a microchip mostly used for business premises access or electronic payment.

Healthcare Industry Standardization (UnitedHealth Group)

Currently, providers are faced with common problems concerning the processing of claims. A high percentage of claims are rejected upon submission, and many are never resubmitted. The cost of reprocessing is high. A large percentage of claims are rejected due to missing or inaccurate information. An enrollee's medical identification card is the primary source of member information. There is also a lag time between rendering the service and getting paid.

Swipe/smart card technology can improve the process of submitting and paying claims by allowing access to relevant payer information. An enrollee's card will act as a trigger/key that could work in conjunction with databases and the internet. Any system that is developed needs to be easy, use current technology, and be flexible as well as being HIPAA compliant.

The cards that could be used include financial service cards such as credit cards. Starting in 2007, three track magnetic strip cards could allow a person's health records and eligibility to

be stored on the third track. This card could also be linked with Healthcare Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), Healthcare Reimbursement Accounts (HRAs), or lines of credit, which would assure that providers are appropriately paid.

Consumer Directed Health Plans and Provider Needs (Greg Labow, Healthcare Financial Management Association)

With the structure of benefits changing and with the advent of consumer directed health plans, providers must collect more information from the patient to determine patient cost and if HRAs, HSAs or FSAs have been set-up to facilitate these costs.

Swipe/smart cards can assist by providing a mechanism to directly collect the patient's cost share obligation from his HSA, FSA, or HRA. To help assure adoption, any mechanism developed should not be proprietary and needs to be available to all.

California Physicians Group (CAPG)

It is important that the California healthcare delivery model evolve to better meet the changing needs of California consumers. Quick and effective mechanisms need to be developed to insure the integration of high deductible products into the California delivery system. Technology platforms need to be standardized so that all insurers and providers can readily communicate electronically. The California healthcare delivery industry needs healthcare service plans to quickly agree and adopt a single standard for the technology.

Simplifying the Administrative Work in Getting Paid (California Medical Association)

There is currently a need to move forward aggressively with technology to improve efficiencies and eliminate needless work. Currently, provider revenue cycles consist of scheduling an appointment, check in/out, documentation and coding, billing (clean claims), collections, and payment applications. With this process, a significant percentage of claims do not get paid on the first submission. Also, the length of time for accounts receivable ranges from 26 to 36 days.

With the advent of high deductible/consumer directed health plans, there is usually little or no reimbursement from the plans. At the same time, providers do not have an efficient method of determining a patient's payment obligation. This leads to higher collection costs, delays in payment, and a high risk of non-collection.

Technology assists a provider in determining a patient's eligibility/benefits. There are present limitations regarding eligibility/benefits databases which are complicated by numerous PPOs, Medicare, Workers' Comp, and self-insured plans. Also complicating the picture is varying rules, payer security and clearinghouse services. Determining the amount the patient owes is also problematic since it varies by payer and by product line. Office technology itself varies with providers using various types of systems including Windows, Macintosh, and Unix/Linux.

Currently, nobody does real time adjudications and there is a lag in data. The way claims adjudication is done does not make sense. Unless there is a substantial change in the way the payers handle claims, just having the swipe card will not improve the current limitations.

III. Presentations on Quantifying the Value of the Integrated Care Deliver Model

Department Comments

The Department is proposing potential solutions in the form of separate regulatory packages to solve longstanding problems that have permeated the industry. Those problems relate to provider's balance billing enrollees; the reasonable and customary value of non-contracted emergency services; and the lack of a fast, fair and efficient way to resolve disputes regarding the reasonable and customary value of non-contracted emergency services.

The Department proposes to establish an Independent Dispute Resolutions Process (IDRP) as a fast, fair and efficient way to resolve disputes. Participants will be allowed to reject the arbitrator's decision and litigate the issue in civil court.

The Department requests the FSSB to examine the current criteria used to determine the reasonable and customary value of non-contracted emergency services. The current criteria, which were based on a Workers' Compensation case titled *Gould,* lack specificity and the regulation does not give a weight to each criterion.

Consistent with the Governor's July 25th Executive Order, the Department also proposes to ban the practice of balance billing enrollees for services that are supposed to be covered by the plan.

Public Comment

As stated in the *Gould* case, Workers Compensation law requires providers to use a fee schedule. Workers Compensation law allows for payment in excess of the fee schedule if the amount was the providers usual fee. The *Gould* criteria were used to determine if a provider was entitled to an amount higher than the fee schedule. The managed care dynamic is quite different and not directly comparable. When looking to establish the reasonable and customary value of the services provided, the criteria needs to add back in the payment side of the equation, which would have been considered if *Gould* weren't a Workers' Compensation case.

Concern was further expressed that when going through this regulatory process regarding the reasonable and customary criteria, the FSSB should consider what is actually being paid in the market place.

With emergency care, there is no opportunity for an enrollee to go to a contracted provider or even to negotiate a rate prior to the services being rendered. The care provided to the

uninsured and to those in government subsidized programs amounts to about a one billion dollar annual shortfall for providers. Additionally, there is an issue as to whether the Department has the authority to ban balance billing. Although the IDRP seems promising, banning balance billing seems premature until the IDRP is tested.

Concern was expressed regarding the use of contract rates. Plans are able to leverage contract rates that are not favorable to providers. Concern was also expressed regarding the use of Medicare since those rates will either remain constant or decrease over time.

Concern was expressed regarding the adequacy of Plan networks and the percentage of premiums going to profit and administrative cost.

Concern was expressed that emergency physicians have both a moral and legal obligation to provide services to all patients seeking treatment at an emergency department. For California emergency physicians, this leads to an average of $132,000 in uncompensated services to the poor and uninsured. When the Department makes its decision regarding the reasonable and customary criteria, the data that is collected should be independently validated and not just anecdotal in nature.

An example of the billed charge dilemma was presented. An enrollee had a 23 hour stay in a hospital. The patient was 67 years old and would have qualified for Medicare, but the patient was employed and had HMO coverage. The billed charge for the service was $115,000 and was based on the applicable charge master, while the Medicare rate would have been $9,700. In this example, it is argued that the $115,000 was not reasonable and that another standard should be used, besides a standard based on billed charges.

Concern was again expressed regarding the use of anecdotal evidence in this process. The issues concerning billed charges and charge masters are complicated. Also, volunteer guidelines have been developed for hospitals for both the uninsured and under insured.

IV. Closing Remarks/Next Steps

The next Financial Solvency Standards Board meeting is scheduled for Wednesday, October 4, 2006, commencing at 9:00 a.m. at CalPers Headquarters at Lincoln Plaza North, Room 1190, 400 P Street, Sacramento, California 95814. (Revised to Wednesday, September 13, 2006, at 9:00 a.m. at the Burbank Hilton.)